Trilogy Healthcare Services, LLC
#386143

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 10/6/11
Amount 720.00

RECEIVED
OCT 06 2011
OFFICE OF INSPECTOR GENERAL

I. IDENTIFICATION

Name **Cedar Ridge Health Campus**

Address **1217 U.S. Highway 62E**

City/County/Zip **Cynthiana, KY 41031**

Telephone number **(859) 234-2702**

Administrator **Melissa Larmour**

Date facility operation began at current address **February 2005**

Date facility began operation under current owner **September 1, 2002**

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	48	48
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	[Profit]	Individual
County	Nonprofit	Partnership
City		[Corporation]
[Private]		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Trilogy Health Services, LLC
1650 Lyndon Farm Court, Suite 201
Louisville, KY 40223

(OVER)

11/31

If facility owned or leased by a corporation, complete the following:

Name of corporation _____

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
Trilogy Health Services, LLC	
1650 Lyndon Farm Court, Suite 201	
Louisville, KY 40223	

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative	Title	Date
	Paul Plevyak, SVP - Finance	9-26-11

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)